

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
HUMIRA (adalimumab) for **PLAQUE PSORIASIS**

Patient name: _____ Medicaid ID #: _____
Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____
Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____
Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____
Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992** note the new fax number

CRITERIA:

- ▶ Age requirement: 18 years old and older
- ▶ Diagnosis of moderate to severe Plaque Psoriasis
- ▶ History of incomplete response or intolerance to at least one appropriate systemic agent or photo therapy.
- ▶ Negative TB skin test within the past 12 months or history of treatment for latent TB infection.
- ▶ Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- ▶ Dermatology consultation within the last 60 days.
- ▶ Humira may not be given with other biologic agents such as Interferon, experimental medications or combinations.

NOTES:

This form is for Non-Traditional clients (blue card) only. Traditional clients (purple card) may receive this medication without a Prior Authorization.

AUTHORIZATION:

1 year

80mg initial dose followed by 40mg every other week starting 1 week after initial dose.

RE-AUTHORIZATION:

An updated letter of medical necessity or progress notes showing improvement or maintenance with medication

02/15/11

<http://health.utah.gov/medicaid/pharmacy>